COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES **Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)** **Medicaid Redetermination**	**AGENCY USE ONLY** DATE RECEIVED:	
	CASE NAME/NUMBER:	
	LOCALITY:	WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local department of social services.

1. IDENTIFYING INFORMATION

LAST NAME: FIRST NAME: MI: SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP: STATE OF RESIDENCE:

MAILING ADDRESS (If different): CITY: STATE: ZIP: HOME PHONE #: DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ BLACK/AFRICAN-AMERICAN ☐ ASIAN ☐ ASIAN AND WHITE ☐ ASIAN AND BLACK
☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE AND WHITE ☐ BLACK/AFRICAN-AMERICAN AND WHITE
☐ AMERICAN INDIAN/ALASKAN NATIVE AND BLACK/AFRICAN-AMERICAN ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER: _____

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

3. STATEMENT OF CONTINUING TREATMENT

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS CURRENTLY RECEIVING TREATMENT FOR BREAST OR CERVICAL CANCER.

NAME OF MEDICAL PROVIDER: _____

SIGNATURE OF MEDICAL PROVIDER : _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- This redetermination is used only to determine continued eligibility for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____

Signature or Mark **Date**

_____ _____

Witness/Authorized Representative **Date**

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA) MEDICAID REDETERMINATION

FORM NUMBER - 032-03-653

PURPOSE OF FORM - This form is the Medicaid redetermination form for women who have been screened and diagnosed with breast or cervical cancer by a medical provider operating under the Center for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and who have been certified as needing treatment.

USE OF THE FORM - This form is used to collect the information needed to determine continued Medicaid eligibility in the BCCPTA covered group and enroll the eligible woman in the MMIS. Continued eligibility in the BCCPTA covered group cannot be determined unless the recipient's medical provider verifies continued treatment for breast or cervical cancer.

NUMBER OF COPIES - Original.

DISPOSITION OF FORM - The original is filed in the case record.

INSTRUCTIONS FOR PREPARATION OF THE FORM

Section 1: Section 1 is used to collect identifying information for the applicant/recipient.

Section 2: Section 2 is used to obtain the nonfinancial information used to determine eligibility in the BCCPTA covered group.

Section 3: Section 3 is the certification that the woman continues to receive treatment for breast or cervical cancer. This certification must be signed by the recipient's medical provider or the recipient must provide a written statement from her medical provider verifying continued treatment for breast or cervical cancer.

The rights and responsibilities and voter registration are on the reverse side of the form.